

CROWSON

v

LAROWE

DR. JUDD LAROWE

June 06, 2018



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June 06, 2018

Dr. Judd Larowe

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IN THE UNITED STATES DISTRICT COURT

CENTRAL DIVISION

MARTIN CROWSON,

Plaintiff,

VS.

JUDD LAROWE, BRET LYMAN, et al.,)

Defendant.

$$\begin{array}{c}) \\) \\) \\) \\) \\) \\) \\) \\) \end{array}$$

COPY

) Case No.
) 2:15-CV-880-RJS

) Judge Tena
) Campbell

DEPOSITION OF DR. JUDD LAROWE

Taken at the Courtyard Marriott
185 South 1470 East
St. George, Utah

On Wednesday, June 6, 2018
At 9:03 A.M.

Reported by: J. Elizabeth Robison, RPR, CCR

June 06, 2018

<p style="text-align: right;">2</p> <p>1 A P P E A R A N C E S</p> <p>2 FOR THE PLAINTIFF:</p> <p>3 Ryan J. Schriever, Esq.</p> <p>4 ryan@schrieverlaw.com</p> <p>5 SCHRIEVER LAW FIRM</p> <p>6 51 East 800 North</p> <p>7 Spanish Fork, Utah 84660</p> <p>8 801.574.0883</p> <p>9</p> <p>10 FOR THE DEFENDANT JUDD LAROWE:</p> <p>11</p> <p>12 Shawn McGarry, Esq.</p> <p>13 smcgarry@kipbandchristian.com</p> <p>14 KIPP AND CHRISTIAN</p> <p>15 10 Exchange Place, Suite 400</p> <p>16 Salt Lake City, Utah 84111</p> <p>17</p> <p>18 FOR WASHINGTON COUNTY DEFENDANTS:</p> <p>19</p> <p>20 Brian Graf, Esq.</p> <p>21 brian.graf@washco.utah.gov</p> <p>22 WASHINGTON COUNTY ATTORNEY'S OFFICE</p> <p>23 33 North 100 West</p> <p>24 Suite 200</p> <p>25 St. George, Utah 84770</p> <p>435.986.2610</p> <p>Frank D. Mylar, Esq.</p> <p>Mylar_law@me.com</p> <p>2494 Bengal Boulevard</p> <p>Salt Lake City, Utah 84121</p> <p>ALSO PRESENT:</p> <p>James Kenner</p> <p>EXAMINATION INDEX</p> <p>DR. JUDD LAROWE PAGE</p> <p>By Mr. Schriever 3</p> <p>By Mr. Mylar 63</p> <p>By Mr. Schriever 70</p>	<p style="text-align: right;">4</p> <p>1 Q. All right. And that was a number of years</p> <p>2 ago?</p> <p>3 A. It was. Probably at least a decade.</p> <p>4 Q. Okay. Well, by way of refresher, then --</p> <p>5 and I know you've had a chance to talk to</p> <p>6 Mr. McGarry, who is an excellent attorney -- but</p> <p>7 the deposition is our chance to just find out what</p> <p>8 you would be able to testify to if we were to get</p> <p>9 to trial. So you're under oath. It's the same as</p> <p>10 being in trial, except there's no judge here.</p> <p>11 There's no jury, and we're given a little bit more,</p> <p>12 latitude to just find out things about the case.</p> <p>13 So I'm going to ask you things about your</p> <p>14 background, qualifications, what you do with the</p> <p>15 Department of Corrections, what your practice is,</p> <p>16 and then any knowledge or memory you have of the</p> <p>17 specific events related to this case.</p> <p>18 Does that make sense?</p> <p>19 A. Yes, it does.</p> <p>20 Q. Okay. You're answering audibly, which is</p> <p>21 exactly what we need you to do, because we are</p> <p>22 making a transcript of the deposition. And a lot</p> <p>23 of times in conversation we have speech patterns</p> <p>24 that make it really casual, like saying "uh-huh" or</p> <p>25 "huh-uh." And that requires our court reporter to</p>
<p style="text-align: right;">3</p> <p>1 P R O C E E D I N G S</p> <p>2 * * *</p> <p>3 DR. JUDD LAROWE,</p> <p>4 having been first duly sworn to testify to the</p> <p>5 truth, the whole truth and nothing but the truth,</p> <p>6 was examined and testified as follows:</p> <p>7 -oOo-</p> <p>8 EXAMINATION</p> <p>9 BY MR. SCHRIEVER:</p> <p>10 Q. Dr. LaRowe, my name is Ryan Schriever. I</p> <p>11 represent an inmate by the name of Martin Crowson.</p> <p>12 Do you know Mr. Crowson?</p> <p>13 A. I do not.</p> <p>14 Q. Okay. We are here to take your deposition</p> <p>15 today.</p> <p>16 Have you ever had a deposition taken</p> <p>17 before?</p> <p>18 A. Once, a number of years ago. I'm not even</p> <p>19 sure when.</p> <p>20 Q. Okay. What did that case involve?</p> <p>21 A. I was asked to be an expert witness in a</p> <p>22 case where a patient had been on Coumadin and</p> <p>23 things went awry.</p> <p>24 Q. Okay.</p> <p>25 A. So...</p>	<p style="text-align: right;">5</p> <p>1 make -- to interpret what you're saying. So if you</p> <p>2 don't say "yes" or "no" to a yes-or-no question, I</p> <p>3 might remind you just to say "yes" or "no."</p> <p>4 A. That would be fine.</p> <p>5 Q. Okay.</p> <p>6 A. Thank you.</p> <p>7 Q. All right. We also -- I don't anticipate</p> <p>8 that we'll be too long. But if you want to take a</p> <p>9 break at any point, we can do that.</p> <p>10 A. Thank you.</p> <p>11 Q. And if I ask you a question that you don't</p> <p>12 know the answer to or you don't remember, you can</p> <p>13 tell me that you don't know or you don't remember.</p> <p>14 That -- those are fine answers. I may probe around</p> <p>15 the edges to see if we can jog your memory. But I</p> <p>16 -- we need to know what your knowledge is, what</p> <p>17 your firsthand knowledge is.</p> <p>18 Does that make sense?</p> <p>19 A. Yes, it does.</p> <p>20 Q. Thank you.</p> <p>21 Well, to get started, would you please</p> <p>22 state your name for the record?</p> <p>23 A. My name is Judd LaRowe.</p> <p>24 Q. Okay. And LaRowe is spelled -- how do you</p> <p>25 spell LaRowe?</p>

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<p>6</p> <p>1 A. L-a capital R-o-w-e. 2 Q. All right. Judd has two Ds; is that 3 right? 4 A. It does. J-u-d-d. 5 Q. Where do you practice? 6 A. At 1664 South Dixie Drive, Suite D-102 in 7 St. George, Utah. 8 Q. Okay. How long have you been there? 9 A. Ten years at this location. 10 Q. What kind of practice do you have there at 11 that location? 12 A. I have a standard internal medicine 13 practice. So we deal with heart disease, diabetes, 14 basically whatever walks in the door that happens 15 to someone over the age of 17. 16 Q. Okay. Before we get too far down that 17 road -- I want to come back to that, but what is 18 your educational background and training? 19 A. I went to the University of Minnesota in 20 Minneapolis for medical school for four years. I 21 did a one-year transitional internship in Grand 22 Rapids, Michigan. After that, I spent three years 23 as a general medical officer in the United States 24 Navy. I was stationed with the Marine Corps for the 25 entirety of my tour, which was three years. I</p>	<p>8</p> <p>1 Q. Okay. As far as specific issues that you 2 deal with on a regular basis -- since I don't 3 necessarily know what all falls under the umbrella 4 of "internal medicine," it sounds pretty broad -- 5 I'm just going to ask you specific areas in common 6 practice. And this is in your private practice I'm 7 referring to. We'll talk about your involvement 8 with the Department of Corrections in a minute. 9 As far as your private practice goes, do 10 you deal with things like alcohol and drug 11 withdrawal? 12 A. Not very often in my private practice. 13 Q. Okay. How about head trauma or brain 14 injuries? 15 A. I certainly do. 16 Q. Okay. 17 A. Yes. 18 Q. And you're familiar with the signs and 19 symptoms of brain injuries? 20 A. I am familiar with the signs and symptoms 21 of brain injuries. 22 Q. In this case particular, we're talking 23 about encephalopathy. 24 Is that a condition that you're familiar 25 with and treat?</p>
<p>7</p> <p>1 spent nine months in Desert Shield and Desert 2 Storm. 3 After that, I did a full internal medicine 4 residency at the University of Washington in 5 Spokane, so that was three years. At that point, I 6 took a job in Elko, Nevada. I worked for the Elko 7 General Hospital. And at the completion of that 8 term, I actually went out in a partnership in Elko 9 for several more years. I believe it was four more 10 years. 11 And then I was hired by the University of 12 Utah, Department of Cardiology. They had an 13 extension clinic here in St. George. So I moved 14 here. I joined Dr. Alan Skolnick and practiced 15 there for two years. They then sold the practice 16 to IHC, and I wasn't interested in working for IHC 17 at the time. 18 So at that point, I went out on my own. 19 That was 2001. Actually, by the time I went out on 20 my own, it was 2002. So that January. And I have 21 been a private practitioner since that point in 22 time. For a brief period, I had another clinic in 23 Mesquite; Mesquite, Nevada. That was for three 24 years. After that, I just solely practiced in 25 St. George, Utah.</p>	<p>9</p> <p>1 A. It is a condition I'm familiar with. 2 Q. Is that something you treat in your 3 practice? 4 A. I don't have that many patients that have 5 encephalopathy. Just due to our population in 6 general in southern Utah, there aren't that many 7 individuals that have it, so the pool is fairly 8 small to draw from. 9 Q. Okay. You know, just before we got done, 10 I think I should have asked you that, in preparing 11 for the deposition, what records have you reviewed? 12 A. I have reviewed the records from DRMC and 13 the records from Washington County. 14 Q. Okay. Does that include the log notes of 15 the -- like, the nurse's notes of -- 16 A. It does include those notes. 17 Q. Okay. All right. In your involvement 18 with the prison, when did you become involved with 19 the -- with Purgatory jail? 20 A. I don't actually remember the exact date. 21 I believe it was 2002, but I'm not positive on the 22 actual start date. 23 Q. And your job there is medical director; is 24 that correct? 25 A. I am a -- I'm a private consultant or a</p>

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<p style="text-align: right;">10</p> <p>1 private contractor. I provide medical care for the 2 inmates in coordination with the medical department 3 at Purgatory. So I'm not actually the medical 4 director. I believe that title falls to Jon 5 Worlton.</p> <p>6 Q. All right. And is it -- okay. Private 7 contractor. Let's just talk briefly about what the 8 terms of your arrangement with the jail are. 9 Are you on a flat fee, or do they pay you 10 by hour, or how does it work? 11 A. It's a flat fee. 12 Q. Do they pay you monthly for that? 13 A. They do. 14 Q. Is that the same regardless of the amount 15 of time you put in working there? 16 A. Yes, it is. 17 Q. As a private contractor, do you have 18 access to their record-keeping systems? 19 A. Only when I'm on site. 20 Q. No remote access, then? 21 A. There is not. 22 Q. Do -- how does the -- how do the employees 23 at the jail communicate with you? 24 A. Several methods. Either via phone or text 25 or faxes, and they will either fax my office, call</p>	<p style="text-align: right;">12</p> <p>1 Q. Okay. In 2014, Mr. Borrowman was working 2 at the jail as a nurse when this happened. 3 Did you have another nurse practitioner or 4 a physician's assistant that helped you at that 5 time? 6 A. I did. Her name was Amy Benedict. 7 Q. Does Amy still work for you? 8 A. She does not. 9 Q. When did Amy stop working for you? 10 A. I believe March of last year. 11 Q. Is she a nurse practitioner -- 12 A. Oh, I'm sorry. 13 Q. Oh, go ahead. 14 A. Actually, June of last year. 15 Q. Is she a nurse practitioner or a 16 physician's assistant? 17 A. Nurse practitioner. 18 Q. Do you know where she is now? 19 A. She is working for the Heart of Dixie, a 20 cardiology group in town. 21 Q. Do you know if Amy had any involvement 22 with Mr. Crowson's case? 23 A. None whatsoever. 24 Q. Outside of the jail's record-keeping 25 system, do you keep any records on inmates?</p>
<p style="text-align: right;">11</p> <p>1 my office, or call my cell phone. So I'm available 2 24/7. And on the rare times when I'm not, I have a 3 nurse practitioner who covers. 4 Q. Who's that? 5 A. His name is Ryan Borrowman. 6 Q. Okay. I've met Mr. Borrowman. 7 A. I imagine you have. 8 Q. But I hadn't put two and two together that 9 he was working for you now. 10 A. He is. 11 Q. Okay. How long has Mr. Borrowman worked 12 for you? 13 A. Since August of last year. 14 Q. All right. When did you first get to know 15 Mr. Borrowman? 16 A. When he started working at the Purgatory 17 facility. 18 Q. How long has he been a nurse practitioner? 19 A. I think three years, but I'm not positive. 20 Q. As far as a typical week goes, how much 21 time do you spend at the jail? What's your 22 schedule? 23 A. Time spent at the jail might be an hour, 24 hour and a half. But I am in contact with the jail 25 multiple times every day.</p>	<p style="text-align: right;">13</p> <p>1 A. I do not. 2 Q. Do you keep any log of phone calls that 3 you receive? 4 A. I do not. 5 Q. If you receive a fax from someone at the 6 jail, is that kept anywhere? 7 A. If I receive a fax from the jail, I 8 respond to the fax and send it back to them, so 9 that that would be where the record would stay. I 10 don't keep any independent files. 11 Q. All right. So you, personally, do not 12 have any files related to Mr. Crowson at all? 13 A. I do not. 14 Q. Okay. Do you have any independent memory 15 of these events at all? 16 A. I do. 17 Q. What do you remember? 18 A. The best that I can recall, I remember 19 getting a phone call from Mike Johnson. And what 20 he relayed to me was that a patient was having some 21 difficulties, as far as confusion, and the vital 22 signs were not very revealing. They were pretty 23 reasonable at the time. And I remember -- what I 24 remember independently is that we ordered some 25 blood work, a chest x-ray. I just wanted to get a</p>

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<p style="text-align: right;">14</p> <p>1 better feel for what was going on, because his case 2 was not clear-cut. And we moved him, at that 3 point, into booking for closer observation. 4 And then I also remember a call from Ryan 5 Borrowman, and at that time, the vital signs had 6 changed. They had gone outside of the normal 7 range. I believe most specifically the pulse rate 8 had risen. And at that point, you know, I elected 9 to have him transported to the emergency room. 10 Those are my only recollections of the 11 plaintiff. I actually don't recall any 12 interactions prior to that or after that. I'm not 13 even sure I saw him in sick call, so I just don't 14 recall. 15 Q. Okay. Do you remember, with Mike Johnson, 16 was it one phone call or -- 17 A. I only recall one phone call on that. 18 Q. Okay. As far as evaluating patients, it's 19 true you rely on nurses there in large part when 20 you're not there; right? 21 A. I do. 22 Q. In fact, there's no other way to do it, is 23 there? 24 A. There is not. 25 Q. They've got to be your eyes and ears?</p>	<p style="text-align: right;">16</p> <p>1 Q. How often do you have contact with 2 Mr. Johnson? 3 A. Quite often. Whenever he works a shift, I 4 will get phone calls. So I have contact with the 5 nursing staff at Purgatory daily. 6 Q. All right. I want to go back to that 7 phone call with Mr. Johnson. 8 You said you ordered blood work? 9 A. I did. 10 Q. What were you looking for? 11 A. Any clues as to what was going on. 12 Anything that would help in the evaluation of the 13 plaintiff. 14 Q. Okay. 15 A. So I ordered a CBC, which is a complete 16 blood count. And a comprehensive metabolic panel, 17 and that looks at a variety of items. It can give 18 you an idea about whether or not the patient might 19 be acidotic or septic. It can give you an idea 20 about kidney function, liver function, 21 electrolytes, fasting blood sugar. So it's quite 22 valuable in assessment. 23 Q. Okay. And when you order -- had that 24 ordered, were you looking for anything specific, or 25 were you -- is it just sort of a, "Hey, this is a</p>
<p style="text-align: right;">15</p> <p>1 A. They are. 2 Q. Do you perform any training of the nurses 3 there or the staff? 4 A. I do not. 5 Q. Do you have any interactions with Jon 6 Worlton about training? 7 A. I don't recall that I have. 8 Q. If someone there were to ask you to come 9 provide training to the staff, is that something 10 that you would be able to do? 11 A. I would. 12 Q. Have you ever had any communications with 13 Jon Worlton about this particular case? 14 A. The only communications I've had was that 15 there would be a case. 16 Q. Did you speak with him at all about his 17 involvement or lack of involvement? 18 A. I specifically did not. 19 Q. Okay. How about Ryan Borrowman? Have you 20 spoken with Mr. Borrowman about the case? 21 A. We have specifically not. In fact, we 22 discussed not discussing the case. 23 Q. Okay. And the same question with Mike 24 Johnson? 25 A. We have not discussed the case.</p>	<p style="text-align: right;">17</p> <p>1 general diagnostic tool that we can use, and if 2 there's clues there, we can follow up on that kind 3 of thing"? 4 And I don't mean to put words in your 5 mouth, but I think you understand where I'm -- 6 what the generalization of my question is. 7 A. I do. It was a general evaluation, 8 because of the patient's vague complaints. 9 Q. Okay. 10 A. I was hoping to get some clue as to where 11 to go next. Also ordered a chest x-ray. His 12 oxygen saturation was normal, but it was a little 13 less than I expected for a young individual. So we 14 ordered a chest x-ray as well. 15 Q. Okay. Again, was that just for general 16 diagnosis, or were you looking for something 17 specific? 18 A. I was looking for perhaps a start of a 19 lower respiratory infection that might explain a 20 lot of the symptoms that he was having. So that 21 was more targeted at the low-normal oxygen 22 saturation. So even though the oxygen saturation 23 was normal, once again, I still expect a young man 24 to be a little bit higher than that. So I thought 25 maybe that would be a clue.</p>

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<p style="text-align: right;">18</p> <p>1 Q. Okay. Did the chest x-ray reveal anything 2 useful to you? 3 A. No, it did not. 4 Q. How about the blood work? 5 A. The patient refused to have blood drawn. 6 So -- and we can't really draw blood unless we have 7 his cooperation in that regard. 8 Q. Okay. And how do you know that the 9 patient refused blood draw? 10 A. I know that he refused the blood draw by 11 the notation in the CorEMR, the charting that was 12 done at the -- at Purgatory. 13 Q. Do you have that in front of you? 14 A. I don't know if I can find it. 15 Q. Well, maybe I can direct you to it. On 16 the bottom of the page, there's some numbers, and 17 if you'll look at No. '501. 18 A. I don't see '501 or '50-anything. 19 Q. Well, all right. 20 Do you have the -- let me show you. 21 A. Oh, thank you. 22 Q. I'll show you what's marked as 23 WashingtonCrowson '501. 24 Do you recognize this as the CorEMR notes? 25 A. I do.</p>	<p style="text-align: right;">20</p> <p>1 A. Thank you. 2 What's the page number on the bottom? 3 Q. '501. 4 A. On the bottom? 5 Q. Forty-four of 44. 6 A. Let me see if I have that. 7 MR. MYLAR: '501 is probably our number. 8 MR. SCHRIEVER: What's that? 9 MR. MYLAR: '501 is probably our number. 10 MR. SCHRIEVER: It is. I didn't know if 11 he had the Bates number or not. 12 THE WITNESS: I'm not sure where I -- 13 MR. SCHRIEVER: 14 Q. Let me -- 15 A. -- did see that. 16 Q. Let me read to you what it says, too. 17 Down here further, it says, "Patient not 18 willing to hold still at this time." 19 A. Yes, sir, I see that. So I don't -- 20 Q. Maybe reading that -- I don't know. 21 A. I don't recollect, then, where I got that, 22 the other information. 23 Q. Okay. All right. The -- you also 24 indicated that his vitals at that time were not 25 revealing.</p>
<p style="text-align: right;">19</p> <p>1 Q. Okay. And if we look here on 6-28-14, 2 this is talking about the CBC, CMP. 3 Is that the blood work that was ordered? 4 A. It is. 5 Q. And it says it was attempted -- 6 A. Oh, attempted. 7 Q. -- without success. 8 A. Okay. Okay. Then I misspoke. I -- for 9 some reason, I thought that he had declined to have 10 that done. So my mistake on that. 11 Q. And -- well, and I don't -- I'm asking. 12 Because if this is the evidence we have, then I 13 want to make sure that you don't have any 14 independent recollection, or if you do, that we're 15 getting it out of you. 16 A. I'll have to look through the notes again, 17 because I thought that I read that he had declined. 18 But perhaps I did not. 19 Q. Okay. 20 A. In fact, I don't believe I've seen that 21 particular. 22 Q. If you want to take -- if you want to take 23 a minute to look through what you've got and find 24 that, that's fine. I want to make sure we're being 25 accurate here.</p>	<p style="text-align: right;">21</p> <p>1 Have you got that page 40 of 44 -- 2 A. I do. 3 Q. -- in front of you? 4 A. I do, actually. 5 Q. Okay. On 6-25-14, do you see that entry? 6 A. Yes, I do. 7 Q. Blood pressure at 125 over 78? 8 A. Uh-huh. 9 Q. Is that within the normal range? 10 A. I shouldn't have said "uh-huh." Yes, I do 11 see that. And that blood pressure is actually 12 textbook perfect, yes. 13 Q. Okay. "P," does that stand for pulse? 14 A. Yes. 15 Q. That's 58? 16 A. Yes. 17 Q. Is that within the normal range? 18 A. That's actually a little bit lower than 19 the normal range. Normal range being 60 to 100, 20 but in a young individual, that's not an uncommon 21 finding. 22 Q. Okay. The "R" at 20, what does that stand 23 for? 24 A. Respiratory rate. 25 Q. Twenty, is that within the normal range?</p>

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<p style="text-align: right;">22</p> <p>1 A. It is.</p> <p>2 Q. And then the O2 saturation, 90 at 99</p> <p>3 percent?</p> <p>4 A. That's normal.</p> <p>5 Q. Okay. The glucose at 73?</p> <p>6 A. That also is normal.</p> <p>7 Q. All right. And then we've got some notes</p> <p>8 that he's able to verbalize his name, spell last</p> <p>9 name, unable to remember what kind of work he did</p> <p>10 prior to being arrested. And then there's a note</p> <p>11 that says, "Deputies Lyman and Dolgner" -- Dolgner</p> <p>12 is spelled D-o-l-g-n-e-r -- "say that the patient's</p> <p>13 affect is different."</p> <p>14 Is there any -- anything in there that you</p> <p>15 are concerned about at that point?</p> <p>16 A. Yes, that he's confused, and his affect is</p> <p>17 different.</p> <p>18 Q. Okay. Now, at this time -- this is a note</p> <p>19 from Michael Johnson indicating that he had seen</p> <p>20 Mr. Crowson on June 25th.</p> <p>21 Do you know if you were contacted at this</p> <p>22 time?</p> <p>23 A. I do not recall that.</p> <p>24 Q. Okay. It indicates that he was referred</p> <p>25 to Jon Worlton.</p>	<p style="text-align: right;">24</p> <p>1 notes in here from 6-26 or 6-27.</p> <p>2 Do you know if you were contacted on</p> <p>3 either of those days?</p> <p>4 A. I don't believe I was contacted.</p> <p>5 Q. Okay.</p> <p>6 A. If I had been contacted, there should be a</p> <p>7 note to that effect, and I don't recall being</p> <p>8 contacted.</p> <p>9 Q. All right. 6-28-14, it says, "Patient</p> <p>10 status: Staffed with MD."</p> <p>11 Is that you?</p> <p>12 A. That is.</p> <p>13 Q. Okay. To the best of your knowledge, is</p> <p>14 this the day that you were contacted for the first</p> <p>15 time?</p> <p>16 A. To the best of my knowledge, it is.</p> <p>17 Q. Okay. And this was a phone call with Mike</p> <p>18 Johnson; correct?</p> <p>19 A. Yes.</p> <p>20 Q. Not a FaceTime or a Skype or anything like</p> <p>21 that?</p> <p>22 A. No.</p> <p>23 Q. Did you speak with Mr. Crowson at all or</p> <p>24 just Mr. Johnson?</p> <p>25 A. Just Mr. Johnson.</p>
<p style="text-align: right;">23</p> <p>1 Were you involved in the decision to refer</p> <p>2 him to Jon Worlton at all?</p> <p>3 A. I don't believe that I was.</p> <p>4 Q. Okay.</p> <p>5 A. But I don't recall either.</p> <p>6 Q. Okay. Down in the next box, this is still</p> <p>7 June 25th. It's at 3:23. "Pupils dilated, but</p> <p>8 reactive to light."</p> <p>9 Do you know if Mr. Johnson informed you of</p> <p>10 that fact?</p> <p>11 A. I don't recall being informed of that</p> <p>12 fact.</p> <p>13 Q. Is that something you would be interested</p> <p>14 in knowing about as the doctor?</p> <p>15 A. No. Being reactive light is an</p> <p>16 appropriate response.</p> <p>17 Q. What about the pupils being dilated?</p> <p>18 A. If they're fixed and dilated, that's a</p> <p>19 different story.</p> <p>20 Q. Okay.</p> <p>21 A. Yes.</p> <p>22 Q. But dilated and reactive to light, is that</p> <p>23 okay?</p> <p>24 A. That is okay.</p> <p>25 Q. All right. And then I don't have any</p>	<p style="text-align: right;">25</p> <p>1 Q. Is there a day of the week that you go out</p> <p>2 to the jail?</p> <p>3 A. Usually Tuesdays, sometimes Thursdays.</p> <p>4 Q. Okay. During the time period, from</p> <p>5 6-25-2014 to 7-1-2014, do you know what day you</p> <p>6 went out to the hosp -- or to the prison, if you</p> <p>7 did go out to the prison?</p> <p>8 A. I don't have a clue. I don't remember</p> <p>9 when Tuesday would have fallen in that year. And</p> <p>10 in addition, Tuesdays and Thursdays are my current</p> <p>11 schedule. I've gone Mondays. I've gone</p> <p>12 Wednesdays. So I'm not even sure on that.</p> <p>13 Q. Okay. No record -- do you have a record</p> <p>14 of when you went to the jail?</p> <p>15 A. I do not.</p> <p>16 Q. Do you have a memory of seeing Mr. Crowson</p> <p>17 at all?</p> <p>18 A. I don't recall ever seeing Mr. Crowson,</p> <p>19 either during this time frame or any other time</p> <p>20 frame.</p> <p>21 Q. Okay.</p> <p>22 A. I may have. I just have no recollection</p> <p>23 of it.</p> <p>24 Q. When you do see a patient, do you record</p> <p>25 it in the CorEMR?</p>

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<p style="text-align: right;">26</p> <p>1 A. I do. There is a note for each visit that 2 I perform. 3 Q. Okay. So if you had seen Mr. Crowson, 4 then your name would appear here, in that third 5 column; is that correct? 6 A. I have no idea on where it would occur. 7 Q. Okay. 8 A. So they have an electronic medical record, 9 and I enter in my visits. Where it would appear or 10 not appear, I don't have a clue. 11 Q. All right. Have you seen anything in the 12 records, that you've reviewed, that would indicate 13 that you did, personally, see Mr. Crowson? 14 A. I have seen no records of my personal 15 evaluation of Mr. Crowson. 16 Q. Okay. On 6-28-14, Mr. Johnson noted that, 17 "The BP," I assume that's blood pressure, "is 18 elevated at this time and reported to MD." 19 A. I'm sorry. What day? 20 Q. On 6-28-14, at 2:07 P.M. 21 A. I don't recall that. So... 22 Q. Okay. 23 A. It certainly could have happened. I don't 24 recall. 25 Q. What's -- in terms of what you would have</p>	<p style="text-align: right;">28</p> <p>1 A. We deal with this quite routinely. 2 Q. All right. Let's talk about 3 methamphetamine withdrawals. 4 If a med -- person who's addicted to 5 methamphetamine goes off of the drug, how long does 6 it take for that to get out of their system? 7 MR. MCGARRY: Object to the form. Go 8 ahead. 9 A. Usually 72 hours. Sometimes a little 10 longer. 11 Q. Okay. As far as these symptoms that you 12 called "psychoses" go, is that associated with 13 methamphetamine withdrawals? 14 MR. MCGARRY: Same objection. 15 A. A lot of things are connected with 16 withdrawals. People will be confused quite often 17 during the withdrawal stage. They can be agitated. 18 They can have a multitude of symptoms, including 19 hypertension, diaphoresis, tachypnea, tachycardia. 20 Q. What's diaphoresis? 21 A. Sweating. 22 Q. And the second one, the tachy -- 23 A. Tachypnea is rapid respiratory rate, and 24 tachycardia is rapid pulse rate. 25 Q. Right. How long do those symptoms last in</p>
<p style="text-align: right;">27</p> <p>1 been looking for, what would be the significance of 2 elevated blood pressure? 3 A. Agitation can cause an elevation in blood 4 pressure, certainly. I didn't mean to say "um." 5 Any change in vital signs can be important. But 6 patients, oftentimes, will have an elevation in 7 blood pressure if they're under stress, if they're 8 agitated. So there are any number of things that 9 can contribute to that finding. 10 Q. Okay. If a patient is exhibiting symptoms 11 of being dazed and confused, not oriented, over a 12 period of three days, is that something that is 13 concerning? 14 MR. MCGARRY: Objection. Incomplete 15 hypothetical. You may answer. 16 A. We see a lot of -- a lot of patients that 17 have these very same symptoms. Unfortunately, it 18 is one of the terrible side effects of some of the 19 drug use that we see. You know, many patients can 20 start up normal, and they start using -- you know, 21 the worst drug we see is methamphetamines. And 22 they can develop psychoses. And we see that on a 23 routine basis. So this is not something that is an 24 isolated event. 25 Q. Okay.</p>	<p style="text-align: right;">29</p> <p>1 a person who's withdrawing from specifically 2 methamphetamine? 3 A. Fairly short in duration. 4 Q. Would it be common for them to start two 5 weeks after the person stops using the drug? 6 A. No. It would be uncommon. Unfortunately, 7 there are times when inmates can have access to 8 some of these products, even despite being 9 incarcerated. 10 Q. Sure. Have you seen anything in the 11 records that would indicate to you that Mr. Crowson 12 had access to any drugs? 13 A. That wouldn't be something I would be 14 involved in. I would not have access to any of 15 that information, whether he did or whether he 16 didn't. 17 Q. Were you aware that he had been in 18 solitary confinement for an extended period of time 19 directly before he was moved to booking for -- 20 MR. MYLAR: Objection. Misstates facts. 21 Those facts are not in the record. 22 Q. Are you aware of that -- whether that's a 23 fact? 24 A. I have no idea on that. 25 Q. Okay. How about heroin? Is -- are the</p>

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<p style="text-align: right;">30</p> <p>1 withdrawal symptoms from heroin similar to what 2 they are from methamphetamine? 3 MR. MCGARRY: Object as to form. 4 A. The withdrawal symptoms to heroin, once 5 again, very nonspecific: Nausea, diaphoresis, 6 tachycardia, tachypnea, elevated blood pressure. 7 And those might last longer than methamphetamine. 8 The half-life for heroin is going to be a little 9 longer. 10 Q. Okay. And when you say a little bit 11 longer, what's the time period, do you think? 12 A. I don't know. I couldn't give you a 13 precise opinion on that. 14 Q. What about alcohol withdrawal symptoms? 15 A. They can last longer. Usually, the time 16 of onset is within 72 hours of cessation. But 17 especially when you're talking about delirium 18 tremens, that can go on for days and days. 19 Q. Can it go on for weeks? 20 A. Not weeks. 21 Q. Can it start weeks after? 22 A. No, it cannot. 23 Q. And by "delirium tremens," what do you 24 mean by that? 25 A. The DTs, the typical symptoms: Visual</p>	<p style="text-align: right;">32</p> <p>1 states that these could be present in. 2 Q. Are they consistent with encephalopathy? 3 A. They could be. 4 Q. Now, you reviewed the records from Dixie 5 Regional Medical Center; is that correct? 6 A. I did. 7 Q. Did you agree with the diagnosis of toxic 8 metabolic encephalopathy? 9 MR. MYLAR: Objection. Lack of found -- 10 lack of foundation. 11 A. Without examining the patient, and just 12 based on my review of the records, I would agree. 13 That's a pretty nonspecific clinical diagnosis, so 14 it would cover a broad range of possibilities. And 15 it would be an appropriate diagnosis from what I 16 reviewed. 17 Q. Okay. Did -- having reviewed those 18 records from Dixie Regional Medical Center, do you 19 have an opinion as to what Mr. Crowson's condition 20 or diagnosis would have been during the time he was 21 in Purgatory jail? 22 MR. MYLAR: Objection. Lack of 23 foundation. 24 MR. MCGARRY: Join. Go ahead. 25 A. Would you restate that, please?</p>
<p style="text-align: right;">31</p> <p>1 hallucinations, auditory hallucinations, tactile. 2 I won't call them hallucinations. But you can have 3 odd tactile sensations, confusion, agitation. And 4 then pretty much the same symptoms as we've 5 discussed with the others. 6 Q. Would not knowing what kind of work you 7 had done prior to incarceration be a delirium 8 tremens? 9 A. That's a pretty -- 10 MR. MCGARRY: Object to form. 11 A. -- nonspecific -- 12 MR. MCGARRY: Sorry, Judd. 13 A. Oh. 14 MR. MCGARRY: Object to form. Go ahead. 15 A. Okay. That's a pretty nonspecific 16 complaint. So that could be part of that. 17 Q. Okay. Do you recall receiving any 18 information from Mike Johnson that's not contained 19 in these notes? 20 A. I don't. 21 Q. As you reviewed these notes, did you see 22 anything in there that you thought would be 23 specific, as it relates to a delirium tremens? 24 A. No, I did not. These symptoms are 25 nonspecific. There are a lot of different disease</p>	<p style="text-align: right;">33</p> <p>1 Q. I will try. I -- that's a fair -- that's 2 a fair request that I try to restate that. 3 Given all the information you reviewed, 4 which I believe -- well, let's see here. 5 All the information you reviewed is the 6 CorEMR notes and the Dixie Regional Medical Center 7 notes; correct? 8 A. Correct. 9 Q. You haven't reviewed anything outside of 10 those? 11 A. I have not. 12 Q. Okay. So having reviewed those records, 13 do you have an opinion as to what the appropriate 14 diagnosis for Mr. Crowson was, during the time he 15 was in Purgatory jail, from 6-25-2014 to 7-1-2014? 16 A. Yes, I do. 17 Q. What's that? 18 A. Well, fortunately, I have 20/20 hindsight, 19 and I can say it would be metabolic encephalopathy. 20 Q. Okay. When you are diagnosing a patient 21 with metabolic encephalopathy, what are the 22 symptoms that you're looking for? 23 A. Confusion is one of the large ones. There 24 also is a physical finding called asterixis, which 25 is very typical if you're dealing with hepatic</p>

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<p style="text-align: right;">34</p> <p>1 encephalopathy. Specifically, there is a finding 2 of fetor hepaticus. The breath smells fruity, 3 yeah, oftentimes in these individuals. Sometimes 4 there will be jaundice. They can be quite agitated 5 as well. But once again, those fall under many 6 subheadings. But those are the things you might 7 typically see in that case. 8 Q. Okay. If you suspect that somebody has 9 metabolic encephalopathy, what's the appropriate 10 course of treatment? 11 A. The appropriate course of treatment in 12 that case, several things. One, you treat the 13 agitation. Number two, you also would give them 14 either neomycin or lactulose. Those help reduce 15 ammonia levels. Typically, you'd give them 16 thiamine, because anyone with hepatic 17 encephalopathy is usually thiamine deficient. 18 They're also usually deficient in other vitamins, 19 so we typically give them a multi-vitamin. We give 20 them thiamine. You would treat them with lactulose 21 or neomycin. You would treat their agitation as 22 well. You know, those are the main things -- 23 Q. Okay. 24 A. -- that you would use. 25 Q. What diagnostic tools do you have</p>	<p style="text-align: right;">36</p> <p>1 MR. MYLAR: -- lack of foundation. 2 Q. Permanent injury to the brain? 3 MR. MCGARRY: Same objections. 4 MR. MYLAR: Same objection. 5 A. On that, I -- I'm not sure I can speak to 6 that. I don't believe so. 7 Q. If a patient has encephalopathy, it 8 wouldn't be appropriate to wait seven or eight days 9 to treat them, would it? 10 MR. MCGARRY: Object to form. Foundation. 11 Speculation. 12 MR. MYLAR: I join on those objections. 13 MR. MCGARRY: You may answer. Sorry. 14 THE WITNESS: Okay. Oh. 15 MR. MCGARRY: You were waiting for me to 16 add some more? 17 THE WITNESS: Yes, I was. 18 MR. MCGARRY: Incomplete hypothetical. 19 Sorry. If you want to critique my lawyering, just 20 feel free, Doctor. 21 THE WITNESS: Am I paying you hourly? 22 MR. MCGARRY: Apparently, you're not 23 getting your money's worth maybe. 24 THE WITNESS: Once again, could you 25 restate the question?</p>
<p style="text-align: right;">35</p> <p>1 available to you to diagnose metabolic 2 encephalopathy? 3 A. Once again, the blood work. You can 4 sometimes get a clue. If the acid base balance is 5 out of the norm, that can be reflected in a 6 comprehensive metabolic panel. An arterial blood 7 gas would also tell you some of those items. An 8 ammonia level. Although, an ammonia level needs to 9 be drawn arterially to get the best product. So an 10 arterial draw is something that generally only 11 takes place in the hospital. 12 Q. Okay. How about an MRI? 13 A. I would not say that that's useful. 14 Q. Okay. How soon should a person be treated 15 when they have metabolic encephalopathy? 16 MR. MCGARRY: Object to form. 17 A. You would like to treat that person when 18 you first realize that that's what's going on. 19 Q. Why is that? 20 A. Quicker recovery. 21 Q. Okay. Can encephalopathy cause permanent 22 damage? 23 MR. MCGARRY: Object to the form. 24 MR. MYLAR: Object. Also -- 25 A. Permanent?</p>	<p style="text-align: right;">37</p> <p>1 MR. SCHRIEVER: Yeah. Well, in fact, why 2 don't we just have it read back. Then the 3 objections are on the record. 4 THE WITNESS: All right. Thank you. 5 (Question read by the reporter.) 6 THE WITNESS: No. You would want to treat 7 the patient as soon as you realize what the 8 diagnosis is. 9 MR. SCHRIEVER: 10 Q. All right. Now, I'll represent to you, 11 Dr. LaRowe, that when I -- when we deposed Ryan 12 Borrowman -- 13 A. Yes. 14 Q. -- I'll -- I'm paraphrasing, obviously. 15 So we'll just note the objection on the record 16 already. 17 He didn't have any difficulty identifying 18 Mr. Crowson's symptoms as serious enough to 19 recommend to you that Mr. Crowson be transported? 20 A. Correct. 21 Q. Did anything Mr. Johnson ever tell you 22 give you an indication that he -- that Mr. Johnson 23 thought Mr. Crowson's symptoms were significant 24 enough to be transported? 25 A. No. And our policy -- and I -- the</p>

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<p style="text-align: right;">38</p> <p>1 nursing staff and myself are all on board with 2 this -- is: You know, the patient comes first. 3 Whatever we need to do to make sure we protect the 4 patient. So no. If Mike had felt that the patient 5 needed to be transported or thought there was even 6 a question, we would have transported him at that 7 time. 8 Q. Okay. 9 A. I'm not going to keep someone in the jail 10 when the appropriate course of action is to have 11 them seen in the emergency room. 12 Q. Which makes your ability to rely on 13 Mr. Johnson critical; isn't that true? 14 A. It does. It does. 15 Q. Outside of the -- I know you don't keep 16 notes of -- or records outside the jail. 17 Do you have any procedures or protocols 18 for following up on patients, who you know have 19 been having some sort of symptoms, like being dazed 20 and confused? 21 MR. MCGARRY: Let me just ask for a 22 clarification. 23 MR. SCHRIEVER: Yeah. 24 MR. MCGARRY: You mean -- so a patient who 25 is still an inmate, when you say "following up,"</p>	<p style="text-align: right;">40</p> <p>1 A. Correct. 2 Q. When you have patients under your care in 3 a hospital, is there a -- is there a time period in 4 which the doctor is going to say, "All right. I 5 need to check up on this patient," or is there -- 6 how did that work? 7 MR. MCGARRY: Object to form. Incomplete 8 hypothetical. 9 MR. MYLAR: Join. 10 A. In a hospitalized patient, you would round 11 on them daily. That's a minimum. 12 Q. Okay. And that's the doctor is going to 13 round on them daily? 14 A. Correct. 15 Q. And then the nurses are there in addition 16 to that; right? 17 A. Correct. 18 Q. In the jail system, that's different? 19 A. It's not a hospital. 20 Q. Right. But the purpose of putting him in 21 booking was so that he could be under observation; 22 right? 23 A. Correct. 24 Q. And so the nurses are there checking on 25 him once per shift at a minimum?</p>
<p style="text-align: right;">39</p> <p>1 not somebody who's been transferred to the 2 emergency department or been released from the 3 jail, but is still incarcerated? 4 MR. SCHRIEVER: Correct, and I can make it 5 more specific. 6 Q. For example, in this case, Mr. Johnson -- 7 the records indicate that he contacted you on June 8 28th. 9 Do you have any kind of tickler system or 10 policies or procedures where on June 29th you would 11 call and say, "Hey, what's going on with Inmate 12 Crowson?" 13 A. I don't. Mr. Crowson was transported to 14 booking or moved from wherever he was before to the 15 booking area, which is immediately adjacent to 16 medical. And when they are moved to booking, 17 medical will do rounds on them every shift, and I 18 believe the deputies check on them every 30 19 minutes. And so there's pretty close observation. 20 So that ensures good follow-up. And then if 21 something occurs during their rounds or if they're 22 notified by a deputy, they would give me a call. 23 Q. Okay. Now, I'm not necessarily familiar 24 with hospital protocol or the way hospitals work. 25 But you have worked in a hospital; right?</p>	<p style="text-align: right;">41</p> <p>1 A. I believe so, yes. 2 Q. Okay. But there's no procedure for a 3 doctor or a nurse practitioner or a physician's 4 assistant to round on those inmates daily; correct? 5 A. No. There is no provision for that. 6 Q. Okay. Okay. On June 29th, 2014, the note 7 from 7:48 A.M. indicates a heart rate elevated at 8 140. And again, there's a note here that says, 9 "Staffed patient status with MD." 10 Do you recall having a second call with 11 Mr. Johnson on June 29th? 12 A. I did recall, after reading the notes, 13 yes. And then it -- I did re -- recall that, yes. 14 Q. Okay. And this protocol is Ativan two 15 milligrams IM. What does that mean? 16 A. Intramuscularly. 17 Q. Okay. Means give a shot? 18 A. Yes, it does. 19 Q. Why Ativan at that point? 20 A. Ativan has a rapid onset, so I was hoping 21 we'd get a quick response for him. And you know, 22 his symptoms at that time with the agitation, I 23 thought the benzodiazepine would help. 24 Q. And that's for the liver, the 25 benzodiazepine; correct?</p>

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<p style="text-align: right;">42</p> <p>1 A. So is Ativan. They're both in the same 2 family. 3 Q. Are they used to treat alcohol withdrawal 4 symptoms? 5 A. They are. 6 Q. Are they used to treat heroin or 7 methamphetamine withdrawal symptoms? 8 A. They can be, yes. 9 Q. What was the reason that you prescribed 10 them? 11 A. It sounded like he was having symptoms 12 that would be consistent with withdrawal, and it's 13 a good drug generally for agitation. For example, 14 oftentimes, we'll also have patients with 15 psychosis, once again, from meth, and 16 benzodiazepine can calm them down quite a bit. 17 Q. How soon would you expect to see a re -- a 18 positive reaction to the Ativan and the 19 benzodiazepine treatment in a person suffering from 20 alcohol withdrawals? 21 A. That can be difficult. You know, 22 sometimes with alcohol withdrawal, for a medication 23 like Ativan, I've given it hourly. But I was -- my 24 plan in this case was that the Ativan would help 25 with the initial symptoms and give us time to get</p>	<p style="text-align: right;">44</p> <p>1 Q. Okay. Now, on the 29th, were you aware 2 that Mr. Crowson had been in booking since the 3 25th? 4 A. I think the only time I -- I'm not 5 positive when -- of that time frame. I'm not 6 positive that I knew. 7 Q. Okay. 8 A. I -- let me restate that. I didn't know 9 at that time how long he had been in booking. 10 Q. Okay. And we already talked about 11 earlier, but you did not know that he was up in A 12 block -- 13 A. I did not. The first -- 14 Q. -- before that? 15 A. I thought he was -- when I thought he was 16 in booking was when I received the call from Mike 17 Johnson. 18 Q. All right. Down there at the note from 19 6-29-2014 at 3:36 P.M., it's Mr. Johnson's update 20 on his visit with Mr. Crowson at that time. 21 Were you provided information about that 22 visit? 23 A. I don't recall. I don't recall on that. 24 Q. Okay. How about June 30th? 25 There's no note there. Do you have any</p>
<p style="text-align: right;">43</p> <p>1 him started on the Librium and allow that to kick 2 in. 3 Q. What's the time frame you expect them to 4 have a response to that? 5 A. That can be difficult, especially with 6 alcohol withdrawal. Some people, it takes a lot of 7 benzodiazepine to achieve a response. And then 8 other cases, they'll have a response quite rapidly. 9 So that is -- there is a huge amount of 10 variability. 11 Q. Okay. And the patients that have the 12 response rapidly, is that within minutes? 13 A. No. It would probably be within 30 14 minutes to an hour -- 15 Q. Okay. 16 A. -- with a rapid-acting medication like 17 Ativan. Possibly longer with Librium. 18 Q. Okay. Would you expect to take more than 19 a day to have a response? 20 A. It can. It can, but I would hope there 21 would be some improvement. 22 Q. How about two days? 23 A. You know, once again, in some individuals, 24 it takes a lot. But two days, I would hope to have 25 seen a response.</p>	<p style="text-align: right;">45</p> <p>1 recollection of being provided information about 2 Mr. Crowson on June 30th? 3 A. I don't. 4 Q. And then July 1st, 2014, Ryan Borrowman's 5 note indicates he was sent to the ER for more 6 in-depth evaluation. 7 Is that something he discussed with you? 8 A. It is. 9 Q. You didn't have any objection to doing 10 that; right? 11 A. Of course not. 12 Q. And if Mr. Johnson, on June 25th, 2014, 13 would have recommended that, you would have had no 14 objection to that either; correct? 15 A. They are my eyes and ears. 16 Q. Are you aware of any standards or criteria 17 for diagnosing alcohol withdrawal symptoms? 18 A. Yes. 19 Q. What standards are you aware of? 20 A. Oh, we look for agitation. Once again, 21 hallucination, verbal and auditory confusion. 22 Usually, you're going to have the tachycardia. So 23 those are kind of the standard things that are 24 looked for. 25 Q. All right. Anything in these notes or</p>

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<p style="text-align: right;">46</p> <p>1 anything in your recollection from speaking with 2 Mr. Johnson that Mr. Crowson was agitated or 3 suffering from agitation? 4 A. Well, I think the confused part, yes. And 5 if you look at the note on the 29th, he actually 6 looked like he was doing better, 9:43 at that time. 7 So yeah, these symptoms are vague and fit a number 8 of diagnostic criteria. But yeah, he -- I would 9 agree with that, the confusion and that. 10 Q. Okay. And I want to break this down a 11 little bit, because you say you agree. But I'm not 12 sure what we're agreeing with. 13 A. I'm sorry. 14 Q. I want to break this down a little bit 15 more. 16 A. Yes. 17 Q. When you use the term "agitation" in 18 relation to alcohol withdrawal symptoms, describe 19 that for me. What does that look like? 20 A. Oh, it can be a variety of findings. 21 Anywhere from being violent and aggressive to not 22 knowing where you're at, what you're doing, not 23 having a recollection of things that have occurred. 24 You know, the classic seeing spiders on the wall 25 sort of thing. Patients can be terribly</p>	<p style="text-align: right;">48</p> <p>1 Q. All right. How about auditory 2 hallucinations? 3 A. Happens too, yes. 4 Q. Okay. Confusions -- or confusion? 5 A. Pretty typical with withdrawal symptoms, 6 yes, but once again, not specific. 7 Q. Okay. And then tachycardia, that's 8 increased heart rate? 9 A. Anything that causes stress to the system 10 can cause tachycardia, so there are -- there's a 11 huge number of items that fall under that. But 12 being agitated definitely can cause tachycardia. 13 Q. Okay. All right. I'm going to go through 14 these, and we're -- I want to try to create a 15 checklist of the symptoms that Mr. Crowson was -- 16 A. Yes, sir. 17 Q. -- exhibiting, to your knowledge. 18 He was confused; correct? 19 A. Correct. 20 Q. He wasn't aware of -- he didn't remember 21 things? 22 MR. MCGARRY: Excuse me just a moment. 23 Ryan, when you say to his knowledge, just so I 24 don't have to make continuing objections, you mean 25 based upon whatever knowledge he has now, after</p>
<p style="text-align: right;">47</p> <p>1 uncooperative during these times. So that's what I 2 would consider to fall under that heading. 3 Q. Okay. And that's all under the heading of 4 agitation? 5 A. Yes. 6 Q. Okay. Like -- and let me -- I'm just 7 asking this. I'm not meaning to argue with you. 8 But like, you said, "Seeing spiders on the wall." 9 That -- I would consider that a visual 10 hallucination, but does that still fall under the 11 rubric of agitation? 12 A. I think it's semantics really -- 13 Q. Okay. 14 A. -- at that point. I mean, agitation is a 15 very broad term. 16 Q. Okay. And then the hallucinations 17 visually, you gave me the example of spiders 18 climbing on the wall? 19 A. That's kind of the classic one. Pink 20 elephants or whatever else you want to -- you want 21 to describe. But I've had people think they were 22 ice fishing -- 23 Q. Okay. 24 A. -- when I would evaluate them. So it can 25 be pretty wild.</p>	<p style="text-align: right;">49</p> <p>1 reviewing the medical record? 2 MR. SCHRIEVER: Yeah, and speaking with 3 Mr. Johnson. 4 MR. MCGARRY: All right. Fair enough. 5 THE WITNESS: Repeat -- 6 MR. MCGARRY: And speaking with 7 Mr. Borrowman? 8 MR. SCHRIEVER: Mr. Borrowman as well -- 9 MR. MCGARRY: All right. 10 MR. SCHRIEVER: -- yes. 11 MR. MCGARRY: Sorry. 12 MR. SCHRIEVER: 13 Q. So he did exhibit some symptoms of 14 confusion; correct? 15 A. Correct. 16 Q. Then he was known to be dazed and confused 17 while serving breakfast, and he was unable to 18 remember what kind of work he did prior to being 19 arrested. I'm just scanning through here. He was 20 disoriented, and he gave one-word answers to 21 questions. 22 Anything else that you see in there that 23 would be a symptom of confusion? 24 A. Not that I see in there. 25 Q. Okay. On 6-29, it says he didn't remember</p>

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<p style="text-align: right;">50</p> <p>1 the last five days.</p> <p>2 Would that be -- that would be a symptom</p> <p>3 of confusion as well; correct?</p> <p>4 A. I would agree.</p> <p>5 Q. Okay. Anything else?</p> <p>6 A. Not that I'm aware of.</p> <p>7 Q. Okay. Do you see anything in there that</p> <p>8 indicates he was violent or aggressive?</p> <p>9 A. I did not see anything in there, other</p> <p>10 than -- the only possible indication was that he</p> <p>11 wouldn't hold still for the blood draw. But I</p> <p>12 don't know -- that's not characterized in detail.</p> <p>13 So I don't know what transpired there.</p> <p>14 Q. Okay. On 6-28, it says he was</p> <p>15 noncompliant with taking deep breaths.</p> <p>16 Does that -- is that a symptom that you're</p> <p>17 -- that's important in any way?</p> <p>18 A. Well, it would go along with confusion.</p> <p>19 Q. Okay. Any indication of any auditory</p> <p>20 hallucinations that you're aware of?</p> <p>21 A. No, not that I'm aware of.</p> <p>22 Q. Okay. How about visual hallucinations?</p> <p>23 A. Not that I'm aware of.</p> <p>24 Q. How about tachycardia?</p> <p>25 A. On the 29th, his pulse rate was up to 140.</p>	<p style="text-align: right;">52</p> <p>1 you know, it's not impossible to do. So that was</p> <p>2 part of the differential I was wondering about,</p> <p>3 whether or not he might have gotten into something.</p> <p>4 Q. As far as investigating that, to see if he</p> <p>5 had gotten into something, is there anything that</p> <p>6 you could do to determine that?</p> <p>7 A. Possibly a drug screen. But it -- you</p> <p>8 know, either urine or blood possibly would have</p> <p>9 been useful. It depends at the time of drug use,</p> <p>10 even with alcohol, obviously. So that might have</p> <p>11 been useful. So I would leave my answer with that.</p> <p>12 Q. Okay.</p> <p>13 A. Possibly.</p> <p>14 Q. Do you know any specific reason why no</p> <p>15 blood or urine was tested for drugs or alcohol?</p> <p>16 A. I don't have a specific reason why. I</p> <p>17 didn't order them.</p> <p>18 Q. Okay. One of the doctors at Dixie</p> <p>19 Regional Medical notes -- wondered about the</p> <p>20 Librium as being a complicating factor with the</p> <p>21 metabolic encephalopathy.</p> <p>22 Do you recall reading about that?</p> <p>23 A. I do recall reading it. I took a</p> <p>24 different interpretation there.</p> <p>25 Q. Okay. Tell me what that is.</p>
<p style="text-align: right;">51</p> <p>1 And I -- I'm not positive, when Ryan Borrowman</p> <p>2 called me, if there were those types of vital</p> <p>3 signs, tachycardia or any pulse rate issues. I</p> <p>4 just don't recall. But yeah, the tachycardia on --</p> <p>5 let me be specific -- the 6-29-14 at 7:48, that</p> <p>6 could certainly be related to that.</p> <p>7 Q. Okay.</p> <p>8 A. I guess he was tachycardic also on the</p> <p>9 28th, looking at the records.</p> <p>10 Q. Okay. Did the blood work reveal anything</p> <p>11 to you that was helpful?</p> <p>12 A. We didn't get blood work.</p> <p>13 Q. Oh, that's right. You didn't, did you?</p> <p>14 A. No. No.</p> <p>15 Q. That's right. So I guess the answer is</p> <p>16 no?</p> <p>17 A. Correct.</p> <p>18 Q. Okay. Did Mr. Johnson provide any</p> <p>19 indication to you or say anything to you that --</p> <p>20 about a source for any suspected alcohol or drugs</p> <p>21 from Mr. Crowson?</p> <p>22 A. No. He didn't. We did speak about that,</p> <p>23 be -- because it wouldn't be the first time. You</p> <p>24 know, the inmates have been known to brew their</p> <p>25 own. I assume it's not the tastiest, but it's --</p>	<p style="text-align: right;">53</p> <p>1 A. My interpretation was that because</p> <p>2 Mr. Crowson had not been on it long enough, he</p> <p>3 wouldn't have developed a tolerance or an addiction</p> <p>4 to it. So there was no need to taper off of the</p> <p>5 medication. And you know, even an alcoholic -- or</p> <p>6 even in hepatic encephalopathy, I certainly have</p> <p>7 used Ativan in the hospital setting for these</p> <p>8 individuals. Ativan, benzodiazepine is in the same</p> <p>9 family.</p> <p>10 And in fact, in review of his previous</p> <p>11 admission to the hospital, they had used Ativan on</p> <p>12 him as well. So the Librium might have aided in</p> <p>13 some of his confusion, just as a potential side</p> <p>14 effect. But I've used benzodiazepine a lot of</p> <p>15 times on patients with hepatic encephalopathy. So</p> <p>16 I don't think it really had any impact on his case.</p> <p>17 Q. Does -- the side effect of Ativan, does it</p> <p>18 increase mental awareness?</p> <p>19 A. No, it does not.</p> <p>20 Q. Does it decrease confusion?</p> <p>21 A. It can decrease agitation, and in the case</p> <p>22 of alcohol withdrawal, it can decrease confusion.</p> <p>23 Q. Okay. Outside of alcohol withdrawal</p> <p>24 symptoms, what is Ativan used to treat?</p> <p>25 A. Agitation, anxiety. Those are the two big</p>

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<p style="text-align: right;">54</p> <p>1 ones, I would say.</p> <p>2 Q. Librium, the same?</p> <p>3 A. Yes. Yes. They all fall in the same</p> <p>4 purview. Some people also use it for insomnia.</p> <p>5 Q. How long was Mr. Crowson on Librium?</p> <p>6 A. I thought three days, but let me refresh</p> <p>7 my memory.</p> <p>8 Q. Okay.</p> <p>9 A. It looks like we started him on the 29th,</p> <p>10 so three days.</p> <p>11 Q. Okay. Anything to indicate that he was</p> <p>12 given a dose of Librium on the 30th?</p> <p>13 A. I believe there's a record on that, but</p> <p>14 I'd have to refer to the medication distribution.</p> <p>15 Q. Let's do that.</p> <p>16 A. Do you know what page that would be?</p> <p>17 Q. I'll have to look for it as well. Let me</p> <p>18 find it.</p> <p>19 A. Oh, here it is, page 24 of 44.</p> <p>20 And what date specifically were you</p> <p>21 asking?</p> <p>22 Q. Well, just -- let's just see if we can --</p> <p>23 what does it tell us as far as when he was given</p> <p>24 Librium?</p> <p>25 A. I see that he was given a dose on</p>	<p style="text-align: right;">56</p> <p>1 record.</p> <p>2 Q. Dr. LaRowe, before we took the break, you</p> <p>3 had handed me a couple of pages that we didn't have</p> <p>4 in the book. And I'm not saying I don't have them,</p> <p>5 period. I just didn't have them in my book here.</p> <p>6 But these are pages 25 and 26 of 44 from</p> <p>7 the CorEMR records. And they show Librium, or at</p> <p>8 least they purport to show Librium being</p> <p>9 administered.</p> <p>10 Is that your understanding of what they're</p> <p>11 -- of what they show?</p> <p>12 MR. MCGARRY: Well, they show -- I mean,</p> <p>13 you just mean just the first three lines; right?</p> <p>14 MR. SCHRIEVER: Right, on 6-29.</p> <p>15 MR. MCGARRY: Or the first four --</p> <p>16 MR. SCHRIEVER: -- and then --</p> <p>17 MR. MCGARRY: One of them says "refused,"</p> <p>18 but the first four total?</p> <p>19 MR. SCHRIEVER: Right.</p> <p>20 MR. MCGARRY: Okay.</p> <p>21 THE WITNESS: That would be correct.</p> <p>22 MR. SCHRIEVER:</p> <p>23 Q. Okay. Who is Joshua Billings?</p> <p>24 A. He was another nurse out at the Purgatory</p> <p>25 Correctional Facility.</p>
<p style="text-align: right;">55</p> <p>1 6-29-2014 at 3:39. All right. Actually, I'm a</p> <p>2 little confused on that. It says, "IM Ativan given</p> <p>3 in lieu of Librium at that time."</p> <p>4 Q. Okay.</p> <p>5 A. And I don't know why that would be.</p> <p>6 Sometimes it depends on what we have in stock, as</p> <p>7 far as what the pharmacy has delivered. And if</p> <p>8 it's on a weekend, sometimes, we -- you know, we're</p> <p>9 not going to be able to get medication. So it is</p> <p>10 appropriate to substitute one for the other.</p> <p>11 Q. All right. And then do you have pages --</p> <p>12 let's see. That's 24 of 44.</p> <p>13 Do you have pages 25 and 26?</p> <p>14 A. Yes, there we are.</p> <p>15 Q. What does that show?</p> <p>16 A. It shows 6-29 at 6:05 P.M. Librium. 6-30</p> <p>17 at 6:34 A.M., received Librium. 6-30 at 10:52</p> <p>18 P.M., he refused the Librium. 7-1 at 5:45,</p> <p>19 received the Librium. And then after that, he was</p> <p>20 sent -- I believe that's when he was transported.</p> <p>21 Q. All right.</p> <p>22 MR. SCHRIEVER: Let's go off the record</p> <p>23 for just a second.</p> <p>24 (A break was taken.)</p> <p>25 MR. SCHRIEVER: All right. Back on the</p>	<p style="text-align: right;">57</p> <p>1 Q. Okay. Do these notes provide you any</p> <p>2 additional insight into Martin Crowson's condition</p> <p>3 at that time?</p> <p>4 A. The -- with the exception of the fact that</p> <p>5 he refused medication on 6-30 at 10:52 P.M., the</p> <p>6 other times it shows that he was compliant. As far</p> <p>7 as why he refused, I could only speculate.</p> <p>8 Q. All right. I'll give those back to you.</p> <p>9 A. Thank you.</p> <p>10 Q. Let me ask you about the role of the nurse</p> <p>11 in providing healthcare at the jail.</p> <p>12 What -- can you describe for me in your</p> <p>13 words what the role of the nurse is?</p> <p>14 A. I will try. The nursing staff will do</p> <p>15 rounds in respective compartments in the jail,</p> <p>16 whether it's A block, whatever. Inmates, that are</p> <p>17 on prescription medications, will come to med pass.</p> <p>18 So at that point, the nursing staff will interact</p> <p>19 with the inmates and provide them with medications,</p> <p>20 or they may decide not to come for their</p> <p>21 medications or whatever.</p> <p>22 And part of the job also is to ensure that</p> <p>23 the inmate actually takes their medication. For</p> <p>24 example, sometimes inmates will cheat the</p> <p>25 medication. They'll store it in their mouth, spit</p>

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<p style="text-align: right;">58</p> <p>1 it out later, and it can be used as a kind of 2 currency, give it to another inmate or that sort of 3 thing. So they try and ensure that those things 4 don't happen. 5 In addition, inmates can declare what's 6 called a "medical emergency," where they will ask 7 for a nurse to come and visit them and, you know, 8 evaluate them for specific complaints. Inmates 9 also can contact the nursing staff via the kite 10 system, where you'll send a request. As an 11 example, a patient might have a sore throat or 12 symptoms of a urinary tract infection or those 13 sorts of things. So they can request a medical 14 evaluation there. 15 The medical staff will also do intake 16 histories when an individual comes into prison. So 17 part of the booking process, I believe, is that the 18 nursing staff will go over a checklist of questions 19 and try and verify any prescriptions the patient 20 states that they're on, try and get an idea of past 21 medical history issues, current medications, 22 current medical status, any complaints. They also 23 will try and review any notes from the ER. 24 Oftentimes, patients are sent to the emergency room 25 for clearance before they are sent to the prison.</p>	<p style="text-align: right;">60</p> <p>1 someone else and cause harm, too. So we'll try and 2 scrutinize. Just because they come in for a 3 prescription for drug A doesn't mean we are going 4 to provide drug A, if it might potentially cause 5 harm to them or harm to others if they were to get 6 ahold of it. So... 7 Q. Okay. 8 A. It -- that is, you know, to the best of my 9 ability, their role. 10 Q. Okay. What about diagnosis? Do they play 11 a role in diagnosis? 12 A. They play a role in diagnosis quite often. 13 I mean, they will give me the symptomatology, the 14 past medical history, and the patient complaints. 15 They're actually quite good with their exams. I 16 mean, they -- it's been a continuous process for 17 them, seeing these patients day in and day out. 18 So ailments like upper respiratory 19 infections are pretty common for us to deal with, 20 allergy-type symptoms, those sorts of things. So a 21 lot of it is delivering the symptomatology to me. 22 And then at that point, I'll develop a care plan, 23 oftentimes with their insight as well. 24 Q. Do they ever offer you opinions and say, 25 "Hey, I think this person has X, Y and Z. These</p>
<p style="text-align: right;">59</p> <p>1 So they get a medical clearance in the ER, and so 2 the nursing staff will oftentimes evaluate that 3 also. 4 Then we coordinate a list for sick call, 5 you know, for example, on Tuesdays. And they'll 6 review, try and get any pertinent information 7 collected for me when I come in, or if there are 8 things we want to do before I see them in sick 9 call, you know, order blood work, get x-ray 10 testing, get that type of information before I see 11 them. We'll also review any requests for 12 consultative care. For example, an inmate might 13 have come in, who'd had a fracture or something, 14 requiring orthopaedic follow-up, those sorts of 15 things. And the nursing staff also will coordinate 16 care with me by calling me on any specific 17 questions on patients. 18 There are a number of medications also 19 that are medications that we typically wouldn't 20 think of as medications of abuse, but have been 21 used in that role, particularly in correctional 22 facilities. So we try and sift through the 23 medications that an individual is on, to make sure 24 that we're not providing them with something that 25 might be abused or cause harm or be passed to</p>	<p style="text-align: right;">61</p> <p>1 are his symptoms?" 2 A. That's hard to say. I think any of us 3 would do that. You know, a mother coming in with 4 her child would say, "Looks like he has a sore 5 throat, you know." And they certainly have the 6 experience. So they might help out in that way, 7 yes. 8 Q. Okay. In fact, you rely on them to help 9 you out in that way, don't you? 10 A. Absolutely. We have a great corps there, 11 so we've been working together for, gosh, 15 years. 12 Q. Okay. Now, Mr. Crowson's symptoms? 13 A. Yes. 14 Q. Vague; right? 15 A. Correct. 16 Q. You've used that word several times? 17 A. Yes. 18 Q. So there are several things it could have 19 been? 20 A. Yes. 21 Q. And when you were talking with 22 Mr. Johnson, to a large extent, you were relying on 23 his knowledge and experience to provide you insight 24 as to Mr. Crowson's condition; correct? 25 A. Correct.</p>

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<p style="text-align: right;">62</p> <p>1 Q. And then the same with Mr. Borrowman?</p> <p>2 A. Correct.</p> <p>3 Q. And because of the nature of the</p> <p>4 situation, you don't have a choice but to rely on</p> <p>5 them, do you?</p> <p>6 A. I don't, no.</p> <p>7 Q. When you're looking at the CorEMR records,</p> <p>8 are you able to see the entries from prior dates?</p> <p>9 And I'm talking about at the prison. If</p> <p>10 you're at the prison, looking on the computer</p> <p>11 system, can you look at entries from prior dates?</p> <p>12 A. I can look at that, yes.</p> <p>13 MR. SCHRIEVER: Okay. All right. I don't</p> <p>14 have any other questions for you, Dr. LaRowe.</p> <p>15 Thank you.</p> <p>16 THE WITNESS: Thank you.</p> <p>17 MR. MYLAR: I just have a few. Can I</p> <p>18 switch with you, so --</p> <p>19 MR. SCHRIEVER: Yeah, for sure.</p> <p>20 MR. MYLAR: -- it might be easier for the</p> <p>21 reporter?</p> <p>22 (Off the record.)</p> <p>23 ///</p> <p>24 ///</p> <p>25 ///</p>	<p style="text-align: right;">64</p> <p>1 Q. And do you have any knowledge or</p> <p>2 understanding of whether -- or have heard of</p> <p>3 whether inmates have ever shared their medications</p> <p>4 with other inmates?</p> <p>5 A. It's a common concern.</p> <p>6 Q. And --</p> <p>7 A. I've had a number of inmates that have</p> <p>8 transferred their medication to another inmate.</p> <p>9 Q. Okay. And do they do those medications in</p> <p>10 different ways and so on? Are you aware of any</p> <p>11 that they might --</p> <p>12 MR. SCHRIEVER: Objection. Form.</p> <p>13 A. I'm sorry?</p> <p>14 Q. I agree. The form is terrible.</p> <p>15 Do they just ingest it? Do they try to</p> <p>16 shoot it? Do they snort it? Do you know how --</p> <p>17 what kinds of things that the inmates will do with</p> <p>18 that other medication?</p> <p>19 A. Injection is usually not an option.</p> <p>20 Q. Right.</p> <p>21 A. So I have had inmates that have crushed</p> <p>22 certain medications and snorted it, and otherwise,</p> <p>23 it's just ingesting.</p> <p>24 Q. Okay. All right. And can that have an</p> <p>25 effect, a negative effect, on an inmate?</p>
<p style="text-align: right;">63</p> <p>1 -oOo-</p> <p>2 EXAMINATION</p> <p>3 BY MR. MYLAR:</p> <p>4 Q. Hi, Dr. LaRowe. How are you doing?</p> <p>5 A. I'm doing well. Thank you.</p> <p>6 Q. Just have a couple questions, just to</p> <p>7 clarify a couple of things.</p> <p>8 You were asked by counsel on June 26th and</p> <p>9 27th that you did not appear -- it did not appear</p> <p>10 in the records that you talked to anyone at the</p> <p>11 jail on those days; is that correct?</p> <p>12 A. I believe that is correct.</p> <p>13 Q. And if, in fact, the jail is putting him</p> <p>14 on close watch, the medical area in the booking,</p> <p>15 and there's -- and he's stable and his vital signs</p> <p>16 continue to be stable, would there be any reason</p> <p>17 for a nurse or anyone to call you?</p> <p>18 A. I, typically, would not be called.</p> <p>19 Q. All right. And I think you had alluded to</p> <p>20 this, that you've at least heard of or had some</p> <p>21 experience of inmates getting certain kinds of</p> <p>22 drugs or home brew while they're in the jail.</p> <p>23 Has that been your experience sometimes in</p> <p>24 the past?</p> <p>25 A. Correct.</p>	<p style="text-align: right;">65</p> <p>1 A. Of course it can.</p> <p>2 Q. And can it have even the kind of symptoms</p> <p>3 that we saw here with Mr. Crowson?</p> <p>4 MR. SCHRIEVER: Objection. Form.</p> <p>5 Foundation. Go ahead.</p> <p>6 A. It would depend on the medication,</p> <p>7 certainly.</p> <p>8 Q. Sure.</p> <p>9 A. But yes.</p> <p>10 Q. All right. And isn't it true that if a --</p> <p>11 if an inmate comes into the jail and they've been</p> <p>12 in before, because of different drug use or</p> <p>13 different things like that, and they've had a</p> <p>14 history of at least a few years of using illegal</p> <p>15 drugs, do those present a little bit more difficult</p> <p>16 presentation to you, as a physician, in terms of</p> <p>17 trying to deal with and treat an inmate like that?</p> <p>18 A. It would, because there are so many</p> <p>19 variables involved, especially if you're talking</p> <p>20 about an individual that has experimented with a</p> <p>21 number of different medications or drugs in the</p> <p>22 past.</p> <p>23 Q. Uh-huh. Okay. All right. And would they</p> <p>24 be more at risk for some unusual thing happening</p> <p>25 potentially? Can that -- or can that -- can</p>

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<p style="text-align: right;">66</p> <p>1 something unusual happen, in terms of their health, 2 because of their long-term use of illegal drugs? 3 A. If they've had long-term use of 4 medications, there are several things that can 5 happen. Most of us have a fair amount of tolerance 6 to a variety of circumstances, whether -- 7 Q. Uh-huh. 8 A. -- it's taking a drug or other insults, 9 having a fever or those sorts of things. But some 10 people have less -- I'm searching for the right 11 word -- less leeway. For example, a patient, who 12 has borderline dementia, takes a medication. And 13 their dementia will be unmasked -- 14 Q. Uh-huh. 15 A. -- because they just don't have the 16 leeway -- 17 Q. Uh-huh. 18 A. -- that one of us would have. So if 19 there -- if someone has had previous insults, you 20 might then unmask other problems, that you might 21 not otherwise see for years down the road. 22 Q. Okay. In this case, there seem to be at 23 least some thought of the jail staff that they 24 thought that he was withdrawing. When you -- 25 looking back as to what you only knew then, not</p>	<p style="text-align: right;">68</p> <p>1 They'll go through those symptoms. But as long as 2 they don't exhibit seizure activity, delirium 3 tremens, those clear-cut things, we're going to 4 manage them in the facility and do it all the time. 5 The hospital wants nothing do with this. 6 Q. Okay. 7 A. So... 8 Q. And someone can be in withdrawals and not 9 show any DTs; is that correct, too? 10 A. Oh, correct. DTs are at the end of the 11 spectrum -- 12 Q. Uh-huh. 13 A. -- of withdrawing. That definitely can be 14 life threatening. 15 Q. Well, when an inmate goes to the 16 hospital -- let's say before they're an inmate. 17 When they're just being arrested and they 18 go straight to the hospital and they're released to 19 the jail, is that really any different than a 20 hospital releasing them just to go home? 21 MR. MCGARRY: Object to form. 22 MR. SCHRIEVER: Join. 23 A. It is different. In this case, there are 24 times when the hospital might actually keep the 25 patient, if they were going to go home --</p>
<p style="text-align: right;">67</p> <p>1 what you know now, were those reasonable thoughts 2 and information that they might think he's 3 withdrawing, based upon the records? 4 A. It could have been. You know, that was 5 certainly one of the top options in the 6 differential. 7 Q. Okay. All right. And if someone just 8 starts to exhibit some symptoms of withdrawal in a 9 jail, that's not the time necessarily to send them 10 right off to the hospital, is it? 11 A. We deal with withdrawal all the time in 12 the prison setting. And in fact, the emergency 13 room will send these patients to us, you know, when 14 it -- when their symptoms become such -- I'll use 15 alcohol withdrawal as a specific one. Because it's 16 the one we see most commonly, and it's easy to 17 state clearly. But when their symptoms become such 18 that you think they're on the verge of DTs or even 19 if they go into delirium tremens, that can be a 20 life-threatening event. And that's when we send 21 them back. 22 Otherwise, we deal with a lot of their 23 symptoms at the time with what we have available. 24 And usually, it's a Librium taper. They will have 25 the tachycardia, the nausea, the diaphoresis.</p>	<p style="text-align: right;">69</p> <p>1 Q. Uh-huh. 2 A. -- or send them to a rehabilitation 3 facility or something like that. 4 Q. Uh-huh. 5 A. But they will send them to us. So our -- 6 they're going to expect more care out of us. 7 Q. Uh-huh. Okay. All right. But they don't 8 say that in their release at all, do they? 9 A. They do not. 10 Q. They just say that he's released from the 11 hospital? 12 A. Correct. 13 Q. All right. And do you know if Mr. Crowson 14 went to the hospital in this case? 15 A. I don't know that. 16 Q. Okay. And based upon the information that 17 you had in this case, you did not see any reason to 18 transfer Mr. Crowson to the hospital, until you got 19 the information on July 1st; is that correct? 20 A. Correct. 21 MR. MYLAR: All right. I don't have any 22 further questions. 23 MR. MCGARRY: Any questions? 24 MR. GRAF: No. 25 MR. MCGARRY: No questions here.</p>

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<p style="text-align: right;">70</p> <p>1 MR. SCHRIEVER: A couple follow-up 2 questions. 3 THE WITNESS: Yes, sir. 4 -oOo- 5 EXAMINATION 6 BY MR. SCHRIEVER: 7 Q. Mr. Mylar asked you about the options for 8 differential diagnosis, and let's break this down a 9 little bit. 10 Differential diagnosis means what? 11 A. Well, let's call it your "usual suspect." 12 What are your -- what are the most likely 13 conditions that would go along with these symptoms? 14 Q. Okay. And in this case, the usual 15 suspects, you said one of the top was withdrawal? 16 A. Yes. 17 Q. Okay. Context is important there, though, 18 isn't it? 19 A. It is. 20 Q. Because outside the prison, withdrawal 21 isn't one of the top suspects, is it? 22 A. No, it's not. 23 Q. In fact, when he went to the hospital and 24 was treated at the hospital, they didn't consider 25 withdrawal, did they?</p>	<p style="text-align: right;">72</p> <p>1 been seen at the facility before, you could gather 2 a lot of data from that. Breathalyzer possibly 3 could be used, too, in that case. There are 4 certain -- you can't test for huffing, so there's 5 no blood tests for those sorts of things. So yeah, 6 you could eliminate certain groups with the correct 7 testing. 8 Q. And if you were working at the hospital, 9 that would be the standard of care; correct? 10 A. Working in the hospital emergency room 11 setting, I would expect it would be. 12 Q. Okay. And is there a different standard 13 of care in a jail? 14 A. It's not a hospital. It's not an 15 emergency room. 16 Q. Okay. 17 A. So I would expect there would be a 18 difference. 19 Q. So no tox screens at the jail? 20 A. You know, I can't recall that I've done 21 one. It would have to be sent out, because there 22 is no lab at the facility itself. 23 Q. You'd agree with me, in the hospital 24 setting, that tox screen is important, because when 25 you're dealing with a differential diagnosis, it's</p>
<p style="text-align: right;">71</p> <p>1 MR. MYLAR: Objection. Lack of 2 foundation. 3 Q. Based on your review of the records? 4 MR. MCGARRY: Join. 5 A. I don't know that. I don't know that. 6 They had the advantage in reviewing the record of 7 having laboratory studies to review, too. 8 Q. Right. 9 A. So... 10 For example, they had ammonia studies that 11 they could do arterially there; correct? 12 A. Yes. Absolutely. 13 Q. So -- and if a person comes in off the 14 street in the hospital -- and you've had experience 15 in a hospital, so this is -- I think is a fair 16 question -- not knowing what they do for work, not 17 responding to -- with multiple words to questions, 18 appearing dazed and confused, you're going to start 19 looking at insults to the brain in some way as the 20 top suspect, wouldn't you? 21 A. I would actually still look at drug use. 22 Q. Okay. And what would you do to look at 23 the drug use? 24 A. Well, I would do a tox screen. I'd review 25 previous records, you know. If the individual's</p>	<p style="text-align: right;">73</p> <p>1 useful to eliminate -- 2 A. It is. 3 Q. -- certain causes, potential causes? 4 A. I would agree with you. 5 Q. Okay. That was not done in Mr. Crowson's 6 case at the jail, though; right? 7 A. No. 8 Q. Okay. And you'd agree, wouldn't you, that 9 one of the reasons that drugs and alcohol was a 10 suspected cause was because he was in prison or in 11 jail? 12 A. That is a population we take care of. 13 Q. In your interactions with Mr. Johnson, was 14 it your impression that Mr. Johnson thought the top 15 suspect was drug or alcohol withdrawal? 16 A. It was a consideration, but it was -- 17 there was always a question of what else might be 18 going on with him. And that's one of the reasons 19 we moved him to the booking, was to keep an eye. 20 Because it was not clear-cut. You know, the other 21 things that we had to look at. 22 You know, at some point, psychosis has to 23 start somewhere. You know, you have to have that 24 initial event. So you always wonder about someone 25 that might have had previous drug use, because we</p>

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<p style="text-align: right;">74</p> <p>1 see so much psychiatric ailments, as a result of 2 that. They have to -- they have to start 3 somewhere. So that was certainly one issue that we 4 thought about. 5 Infection also is something that you worry 6 about with confusion. So I would have dearly loved 7 to have had the CBC to look at that. We did check 8 the chest x-ray. No signs or symptoms of a urinary 9 tract infection. So you know, there were a number 10 of things we were looking at. It was not 11 clear-cut. 12 Q. Okay. What indications did you see there 13 wasn't any sign of a urinary tract infection? 14 A. Well, typically, in a male, they're pretty 15 aware of that. You know, that's why STDs are 16 detected more easily in men. And women can have an 17 STD that they're not aware of at all for awhile. 18 And I have seen a number of female patients with 19 urinary tract infections that have gone to the 20 point of sepsis before it's ever recognized. 21 Q. So let's go -- let's just do this real 22 quickly. 23 When you're dealing with differential 24 diagnosis, the first step, rather than determining 25 what the cause of the symptoms is, is to eliminate</p>	<p style="text-align: right;">76</p> <p>1 A. No. If there's an -- if there's a thought 2 that we need to transfer them, we always err on the 3 side of transporting. 4 Q. And Mr. Borrowman did? 5 A. He did. 6 Q. Have you spoken with either of them, or do 7 you have any knowledge as to why they viewed this 8 situation so differently? 9 A. I have not. On review of the records, 10 even in Ryan Borrowman's case, I didn't see the 11 vital signs there. I -- it was more of a gestalt 12 on his part, I think, that the patient was doing 13 poorly. There may have been vital signs recorded; 14 I just didn't see them. But if he's going to tell 15 me the patient needs to go, I'm sending him. 16 Q. Do you know what the results of the chest 17 x-ray were? 18 A. They were negative, I believe, in that 19 there was no pathologic process noted. 20 Q. No signs of infection either; right? 21 A. No, there was not. 22 Q. Okay. You talked about -- with 23 Mr. Mylar's questions, you talked about seizures, 24 seizure activity, being a sign of withdrawal; is 25 that correct?</p>
<p style="text-align: right;">75</p> <p>1 other causes; right? 2 So you've got a checklist, and your 3 checklist was alcohol withdrawals, infections, 4 urinary tract infections, respiratory issues. 5 What else am I -- what else am I missing? 6 A. Possibly psychosis. 7 Q. Okay. Did encephalopathy ever make it 8 onto the radar? 9 A. It did not. It did not. 10 Q. Okay. That's in large part because it 11 didn't get onto Mr. Johnson's radar to be conveyed 12 to you; right? 13 A. Well, also, we didn't have -- I didn't 14 have at my disposal the previous admissions. And 15 in fact, from reviewing the chart, I think this was 16 the first time he had been diagnosed with hepatic 17 encephalopathy. I'd -- you know, he'd come in with 18 a mult -- on review of previous hospitalizations, 19 he'd come in with a number of other things, you 20 know, and actually been in the ICU and whatnot. 21 But maybe I missed it, but I didn't see hepatic 22 encephalopathy noted before. 23 Q. Mr. Johnson didn't give you any indication 24 he thought Mr. Crowson should be transferred to the 25 ER, did he?</p>	<p style="text-align: right;">77</p> <p>1 A. It can be, yes. 2 Q. No indication of seizure activity with 3 Mr. Crowson; right? 4 A. There was none noted. 5 Q. Okay. What is the jail policy as to when 6 a patient should be transported to an emergency 7 room? 8 A. I'm not aware of any set policy. There 9 may be. I'm not aware of one. It, usually, is 10 based on a discussion between the nursing staff and 11 myself. 12 Q. Okay. 13 A. Our unwritten policy, you know, is protect 14 the patient, protect our license. 15 Q. What role did Mr. Crowson's prior drug use 16 play in his encephalopathy? 17 MR. MCGARRY: Object to form. 18 A. It could have played a huge role in his 19 hepatic encephalopathy. You're not going to 20 develop hepatic encephalopathy de novo. You have 21 to have injured your liver to the point where it's 22 in a tenuous situation, where one more insult can 23 tip you over the edge where your body is not 24 able -- where your liver is not able to eliminate 25 the ammonia, which is typically what we see go.</p>

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<p style="text-align: right;">78</p> <p>1 And that can happen in various 2 circumstances. For example, IV drug users, you 3 know, you always have to consider the possibility 4 of hepatitis C or hepatitis B. Genetic things like 5 sclerosing cholangitis, injury to the liver based 6 on alcoholic consumption or alcoholic cirrhosis, 7 nonalcoholic steatohepatitis or NASH syndrome. So 8 usually, there has to be an injury, either 9 infectious, toxic, like alcohol, or genetic. Those 10 are the typical ones that we'll see. 11 Q. All right. Hepatitis C, potential 12 contributing factor? 13 A. Of course, yes. 14 Q. Are you aware that Mr. Crowson was 15 diagnosed with hepatitis C? 16 A. I was not, and on his intake form, he -- 17 on review, in my 20/20 hindsight, he -- I believe 18 he did not note that to the staff. 19 Q. Any indication from Mr. Johnson that he 20 was aware that he had hepatitis C? 21 A. I don't recall that. 22 Q. Any indication from Mr. Johnson's notes or 23 from your conversation with him that there was the 24 possibility of a prior insult to the liver that 25 could lead to hepatic encephalopathy?</p>	<p style="text-align: right;">80</p> <p>1 investigating those other potential causes? 2 MR. MCGARRY: Object to form. Incomplete 3 hypothetical. 4 MR. MYLAR: And also calls for 5 speculation. I join in those. 6 A. That one -- that one's hard to say. I 7 think it depends on findings while you're observing 8 them. If they're safe, in that they're taking 9 nourishment, they're drinking water, they're not 10 harming themselves, I think those all play a role. 11 If they're stable, in that their situation is not 12 deteriorating, I think it's fine to continue to 13 watch and gather information. 14 Q. Okay. Let me give you a -- I'll represent 15 to you what a note says, and you can use this. And 16 then I'll give you a question after. 17 A. Okay. 18 Q. My representation is that one of the notes 19 says that a deputy gave Mr. Crowson his clothes and 20 told him to get dressed. Mr. Crowson put his 21 underwear on his head. 22 A. Okay. 23 Q. Is that something that would be -- that 24 you would look at to determine whether or not 25 there's a serious issue happening?</p>
<p style="text-align: right;">79</p> <p>1 A. Not that I recall. 2 Q. If a tox screen had been done and drugs 3 and alcohol were eliminated as causes of this, what 4 would your next step have been? 5 MR. MCGARRY: Objection. Object to form. 6 Calls for speculation. 7 MR. MYLAR: Join. 8 THE WITNESS: I probably would have done 9 the same thing. I would have watched, you know, as 10 long as the vital signs were stable. Because we do 11 see confusion and agitation very commonly out 12 there. So I think the next step -- now, this is 13 purely speculative, you know, and so I can only 14 speak to what we've done in the past. I would have 15 continued observation, continued gathering vital 16 signs and trying to get more information. Might 17 have had him evaluated by mental health people out 18 there, might have considered, "Gosh, is this an 19 individual where we should look at using one of the 20 psychotropic drugs? You know, is this the 21 beginning of his psychosis or schizophrenic-like 22 ailment?" I don't know. 23 MR. SCHRIEVER: 24 Q. How many days is it reasonable to keep a 25 person in a dazed, confused state without</p>	<p style="text-align: right;">81</p> <p>1 MR. MCGARRY: Object to form. 2 MR. MYLAR: Objection. Also calls for 3 speculation. Also lack of foundation. 4 A. That's not an unusual occurrence. We deal 5 with a lot of psychological illness there. In 6 today's day and age, the prison systems house the 7 mentally ill. They can't help but commit a crime 8 when they're on the outside. So we see that type 9 of thing a fair amount. 10 Q. Okay. And if a nurse asked him to take 11 deep breaths and he was unable to follow that 12 simple of an instruction, is that a serious 13 symptom? 14 MR. MCGARRY: Same objections. 15 MR. MYLAR: Join. 16 A. Once again, it is related to his degree of 17 confusion. We've had people weaponize excrement in 18 the prison. So I -- if you're going to throw a 19 bomb, an excrement bomb, you know, that's fairly 20 serious. But we don't send them to the hospital 21 for that. 22 Q. Okay. But my question was: Inability to 23 follow simple instructions, such as take a deep 24 breath? 25 A. These people don't follow those</p>

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1 instructions either. We see that all the time.
2 It's not uncommon.

3 **Q. In a hospital setting, those would be**
4 **viewed differently, though; correct?**

5 A. They would be. They would be. It's a
6 tough situation, because we have individuals that
7 are noncompliant. Oftentimes, there is the issue
8 of secondary gain through their actions, and it
9 makes the whole medical evaluation process that
10 much more difficult.

11 MR. SCHRIEVER: All right. Thank you,
12 Dr. LaRowe. I don't have anything else.

13 MR. MYLAR: I don't have any questions.

14 MR. MCGARRY: We'd like the opportunity to
15 review and sign. If you'll send it to me, I'll get
16 it to Dr. LaRowe.

17 MR. MYLAR: And I would like a electronic
18 version, as well as a manuscript.

19 MR. MCGARRY: Send me everything. Just
20 anything you can bill for to make up for those
21 thousand burpies you missed today.

22 (The deposition concluded at 11:00 A.M.)
23
24
25

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REPORTER'S CERTIFICATE

STATE OF UTAH)
) ss
COUNTY OF WASHINGTON)

I, J. ELIZABETH ROBISON, Registered Professional Reporter, Washington County, State of Utah, do hereby certify:

That I reported the taking of the deposition of the witness, DR. JUDD LAROWE, commencing on Wednesday, June 6, 2018, at the hour of 9:03 A.M.

That prior to being examined, the witness was by me duly sworn to testify to the truth, the whole truth, and nothing but the truth.

That I thereafter transcribed my said shorthand notes into typewriting and that the typewritten transcript of said deposition is a complete, true and accurate transcription of my said shorthand notes taken at said time.

I further certify that I am not a relative or employee of an attorney or counsel of any of the parties, nor a relative or employee of any attorney or counsel involved in said action, nor a person financially interested in the action.

IN WITNESS WHEREOF, I have hereunto set my hand in my office in the County of Washington, State of Utah, this 5 day of July, 2018.

J. Elizabeth Van Fleet

J. Elizabeth Robison, RPR, CCR

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